STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A state relicensure survey was conducted at the facility from July 16, 2018 to July 20, 2018. On entrance, the census included 40 residents.	4 000		
4 095	11-94.1-20(a) In-service education (a) There shall be a staff in-service education program that includes the following: (1) Orientation for all new employees that shall include: (A) Information to acquaint them with the philosophy, organization, program, policies and procedures, practices, and goals of the facility; and (B) Competency evaluation to ensure that staff are able to carry out their respective duties; (2) In-service training for employees who have not achieved the desired level of competence, and continuing in-service education to update and improve the skills and competencies of all employees; (3) In-service training that shall include annually, at minimum, prevention and control of infections, fire prevention and safety, disaster preparedness for all hazards, accident prevention, resident rights including prevention of resident abuse, neglect and financial exploitation, and problems and needs of the aged, ill, and disabled; (4) Competency testing for cardiopulmonary resuscitation to annually certify the nursing staff;	4 095		8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 095	Continued From page 1 (5) Training in oral hygiene and denture care, which shall be given to the nursing staff at least annually; and (6) Appropriate personal hygiene instructions at regular intervals shall be given to all personnel providing direct care and handling food. This Statute is not met as evidenced by: Facility could not produce documentation of training for HazMat, Infection Control, Fire & Safety, Accident Prevention, and Pt's Rights & Problems for S17, S33, and S53.	4 095	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -The Administrator has revised the facility Inservice Policy & Procedure for all direct care staff to include contract workers. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents and contract workers are potentially affected by the deficient practice. -All direct care staff will be required to provide proof they have completed annual inservices that cover the required topics. Employees and contract workers will be given the option to attend inservices held at the facility or utilize outside resources to complete the requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 095	Continued From page 2	4 095	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -The DON and Staff Development Coordinator will create an annual schedule to ensure that all staff are offered the required inservices and given adequate time to complete them. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The Staff Development Coordinator will collect all employees' annual schedule sheets to monitor for completion and follow-up with staff as needed. -The DON and Staff Development Coordinator will review the monthly schedule to ensure that offered inservices cover all required topics.	
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal	4 153		8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 153	Continued From page 3 and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to assist three residents (R) 13, R27 and R37 who required assistance to eat during meal times. Findings include: Record review (RR) of R13 and R37's annual MDS dated 05/12/18 and 07/01/18 respectively	4 153	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -On 8/9/2018 the MDS Coordinator reviewed R27's MDS and proceeded with a Significant Change Assessment. The MDS Coordinator will update R27's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 153	Continued From page 4 identified that these residents require total dependence-full staff performance requiring one person physical assist during meal times. RR of R27's quarterly Minimum Data Set (MDS), an assessment of clinical needs identified that R27 requires Supervision-oversight, encouragement or cueing and setup help only by staff. On 08/07/18 at 1:51 PM called DON who assessed that R27 as "total dependence" at meal times. On 07/17/18 at 12:02 PM during lunch observation found three residents (R13, R27 and R37) sitting in their geri chairs in front of the television waiting to be assisted with their meal. R13, R27 and R37 sat in the front of the dining room as other residents ate their lunch. R27 appeared alert with his eyes open, looking around. R13 and R37 both rested and opened their eyes periodically. These three residents had their hands cleaned with hand sanitizer and lotion applied by staff during the time they waited. At 12:11 PM R27's lunch was set up and he was assisted by CNA19. At 12:16 PM R37's lunch was set up and resident was noted to be sleeping and the tray of food was taken away. R37 was reclined in her geri chair and left sleeping near the table. At 12:28 PM inquired with CNA19 if R13 had been assisted with his lunch and noticed that his clean clothes protector was placed on his chair and had not been used. CNA19 asked CNA11 if R13's food was still available and CNA11 looked at R13 and appeared startled. Inquired with CNA11 and CNA4 why they cleared away dirty plates from other residents when no one had assisted R13 with his lunch. CNA4 stated that she had asked her coworker if R13 was sleeping and she thought he was still sleeping. Inquired if CNA4 should have checked to see if R13 was awake and she agreed that she should have checked on R13 to see if he was	4 153	care plan to reflect the resident's current needs. -The DON will create a dining meal protocol to ensure that all residents who are dependent upon staff for meals (including R13, R27, and R37) will be assisted with meals. The protocol will include prioritizing assisting all residents with meals prior to clearing trays. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents that are dependent upon staff during meals are potentially affected by the deficient practice. -The current staffing ratios during meals will be reviewed and revised based upon acuity (i.e., higher number of residents who are dependent upon staff for ADLs). -During breakfast and lunch, the Activities staff and SWD will assist residents who require encouragement and cueing only. -A random, quarterly check will be performed by the DON to ensure that any potential problems are identified and corrected. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -Each shift the charge nurse will check the intake sheets/charting and assist with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 153	Continued From page 5 awake before clearing away dirty dishes. When asked what the priority is for staff at meal time CNA4 stated that residents eat their meal. Noted at this time that R37 was not at her table, had not eaten her lunch and was taken back to her room in her geri chair. At 12:35 PM went to R37's room to check on her and found her sleeping in her geri chair next to her bed. On 07/17/18 at approximately 2:30 PM met with DON to discuss the lunch observation. DON stated that she talked with the staff and they told her that they were nervous which affected how they did their job. DON told staff to do their job as they have been taught and how they normally work. DON also stated that she assisted R37 with her lunch in her room.	4 153	meals by either directly assisting a resident who is dependent upon staff, or reminding and assigning CNAs to assist residents. -The kitchen staff will be trained on checking that all trays have been served prior allowing staff to clear trays, and to notify the charge nurse promptly for any late trays. -The dining area set-up was reviewed to ensure that residents who are dependent upon staff during meals are given enough time to finish their meals. -A quarterly evaluation of staffing ratios during meals will be performed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The facility assessment will be reviewed and revised annually to ensure adequate resident to staff ratios during meals and based upon acuity.	
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.	4 159		8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 159	Continued From page 6 This Statute is not met as evidenced by: Based on observation, certified nurse aide (CNA) 29 failed to prepare resident (R) 4's lunch drinks (water and supplemental drink) in a sanitary manner in accordance with professional standards for food service safety to prevent the spread of infection. Findings include: On 07/20/18 at 10:53 AM observed CNA29 take R4's lunch tray from the food cart and walk to R4's room. Followed CNA29 into R4's room and observed CNA29 assist R4 set up her lunch tray. CNA29 assisted R4 to a sitting position in her bed, told R4 that it was lunch time and that she was going to assist her. CNA29 performed hand hygiene before taking lids off of the food container and cups. It was noted that R4 was to have nectar thick fluids and CNA29 brought in the container of Hormel Thick and Easy Instant Food and Beverage thickener to add to R4's drinks. CNA29 used a clean spoon to add thickener to each cup and stirred the beverages. It was noted that the liquids were not thick enough and CNA29 needed to add more thickener to each cup. S29 proceeded to stick her ungloved right hand into the container of thickener and dig to reach for the blue scoop that was in the container. At this time CNA29 was asked to stop. It was explained to CNA29 that whatever is on her hand would end up in the resident and could make her sick. On 07/16/18 at 11:53 AM met with DON to discuss what occurred and inquired if this was the practice at the facility and she concurred that this never should have happened. DON confirmed that staff are trained on how to assist resident's	4 159	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -On 7/16/18 the DON immediately disposed of the container of Hormel Thick and Easy Instant Food and Beverage thickener in question. -The Dietary Manager placed a covered container of disposable spoons on each meal tray cart for the staff to access easily during mealtimes. The containers are replenished prior to each meal. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents that require thickened liquids are potentially affected by this deficient practice. -The facility will conduct inservices for all current and new direct care staff on how to properly measure and thicken liquids to attain the correct consistency. -The charge nurse will perform random checks during meals to ensure that the CNAs are adhering to the proper procedure for thickening liquids prior to assisting residents who require thickened liquids. What measures will be put into place or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 159	Continued From page 7 with meals and also are provided training on infection control annually.	4 159	what systemic changes you will make to ensure that the deficient practice does not recur -Quarterly audits will be conducted to monitor the staff□s adherence to the proper procedure of thickening liquids and performing hand hygiene. Ongoing education will be provided as needed for staff who are not in compliance with the proper procedures. -The annual staff inservice curriculum will include a review of the proper procedure to thicken liquids. -The annual staff inservice on infection control will include a review of proper hand hygiene and the spread of infections between residents via direct or indirect transmission. How the corrective action(s) will be monitored to ensure the efficient practice will not recur -The Hand Hygiene Policy & Procedure and Infection Control Policy & Procedure will be reviewed annually and revised as needed. -The infection control quality assessment program will be revised to include hand hygiene and quarterly audits as a process measure to be tracked.	
4 170	11-94.1-42(h) Physician services (h) The facility shall promptly notify the physician, physician assistant, or APRN of any accident, injury, or change in the resident's condition.	4 170		8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 170	Continued From page 8 This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to notify resident (R) 13's physician of a significant weight loss of 13 pounds from June 2018 to July 2018. Findings include: On 07/19/18 at 10:03 AM during record review (RR) found that R13 had an unplanned significant weight loss of 13 pounds from June 2018 to July 2018. It was noted that R13 had a new care plan (CP) in place for unplanned/unexpected weight loss related to poor food intake that was created 07/16/18 by staff (S) 23. On 07/19/18 at 11:39 AM interviewed S23 regarding R13's CP for unexpected/unplanned weight loss. S23 explained that R13's July 2018 weight, 122 lbs., was not inputted into R13's electronic medical record (EMR) after he was weighed in July 2018. S23 explained that during the first week of each month facility staff weigh the residents and inputs these weights into each residents EMR in Point Click Care (PCC). S23 noticed that R13's weight was missing for July 2018 and she inputted R13's weight into R13's EMR in PCC on 07/16/18. R13's weight in June 2018 was 135 lbs. S23 initiated the CP for unexpected/unplanned weight loss on 07/16/18 after she discovered the significant weight loss. Inquired if S23 notified the physician of R13's significant weight loss and she stated "no." On 07/19/18 at 02:15 PM interviewed S4, who stated that she takes the weights of each resident the first week of the month and logs the weights for all the residents in the EMR in PCC and gives	4 170	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -On 7/19/18, R13's physician was notified of the weight loss, and orders were received to start Ensure and weigh resident twice a month. R13's family member was updated and agreed to the new orders. -The DON updated the facility's weighing protocol to include documenting weights in the EHR by the 7th of each month. -On 7/16/18, the MDS Coordinator updated R13's care plan to include the unexpected weight loss. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents who are at high risk for weight loss are potentially affected by the same deficient practice. -The DON will conduct an inservice to educate all direct care staff on the updated weighing protocol, including documentation requirements and parameters for reporting weight gain/loss to the physician. -All charge nurse will notify the physician of any resident weight a weight gain/loss of five (5) or more pounds. -The DON will create and lead a weight	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 170	Continued From page 9 a copy of the Weighing Report to Director of Nursing (DON) with notations of resident weight loss of five pounds or more. S4 stated that she did notate the 13 pound weight loss with R13. Inquired if S4 inputted R13's weight into R13's EMR in PCC and she stated that she believed that she had. S4 appeared shocked when she was shown that S23 had inputted the information into R13's PCC EMR on 07/16/18. On 07/19/18 at 03:17 PM interviewed DON who denied receiving a copy of the Weighing Report for July 2018, stated that since the facility got Point Click Care (PCC) software last year she no longer gets a paper copy of the weights, that she looks in PCC and will see the significant weight change on her computer dashboard. DON stated that she was not aware of R13's significant weight loss until "Monday, July 16, 2018." DON confirmed that R13 had a 13 pound weight loss from June 2018 to July 2018. DON denied being told of this weight loss and stated that S4 would have notified her or RN35. DON denied notifying the physician of R13's significant weight loss. Inquired if any nurse, who worked with R13, documented notifying the physician of R13's significant weight loss and DON stated this information was not found in R13's EMR progress notes. DON confirmed that this would have been documented if it was done. Inquired if this is the practice at the facility, to notify the physician if a resident has a significant change, and DON confirmed that is the facility practice. Requested a copy of facility policy for significant weight loss and was given the Hale Malamalama Weight Loss Protocol. Noted the following in the facility's "Weight Loss Protocol #1; the Rehabilitative Assistant (RA) will weigh the resident within 24 hours of admission to establish a baseline, then at the beginning of each month thereafter. Also	4 170	review committee, consisting of the DON, charge nurse, MDS Coordinator, Dietary Manager, Activities Coordinator, and Social Work Designee (SWD). The committee will convene on the 8th of each month to discuss and implement interventions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -The DON will be provided a hard copy of the monthly weights in addition to accessing the electronic health record (EHR). -The DON will check the EHR on the 7th of each month to ensure that all weights have been recorded. -The weight loss committee will meet on the 8th of each month to review all residents' weights, discuss and implement interventions. -The day shift charge nurse will be responsible for notifying the physician as necessary and relaying any new orders to the resident/family member and the committee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The DON will review the weighing protocol on an annual basis and revise it as necessary. -A quality assurance program for weight	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 170	Continued From page 10 noted the facility's Weight Loss Protocol#10; if resident continues to lose weight (non-intentional) the physician will be notified for medical evaluation and possible lab work." 07/20/18 10:59 AM interviewed Registered Nurse (RN)35 who confirmed that S4 told her of R13's significant weight loss of 13 pounds from June 2018 to July 2018. RN35 stated that she did not notify the physician of this significant change with R13. RN35 stated that she notifies the physician if there is a critical value. RN35 stated that from this experience she was told that a weight loss of five pounds or more is reportable to the physician.	4 170	loss/gain will be implemented and reviewed quarterly.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on record review, staff interview and observation, the facility failed to care plan for R1's fungal infection of the mouth, and R26's anticoagulant use. Findings include: 1) On 07/17/18 at 07:59 AM , record review revealed progress note dated 07/03/18 that reflected that R1 started antifungal medication, Nystatin suspension, 5 ml by mouth, four times a	4 174	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident #1 -Attending physician has clarified that oral lesion can only be removed by surgery on 7/18/2018 at 1:30 PM. The nystatin oral suspension was prescribed to treat a complication, but not intended to resolve	8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 174	Continued From page 11 day, for ten days for "lower gums not improving." On 07/18/18 at 07:31 AM, review of care plan reflected care plan initiated 7/12/18 does not reflect any interventions for R1's fungal infection of the mouth. On 07/18/18 at 11:06 AM, interviewed S22 who searched in facility's electronic medical record and confirmed the fungal infection was not care planned. On 07/18/18 at 11:15 AM, observed R1's mouth with S22 who confirmed that the fungal infection was not fully resolved. 2) On 07/16/18 at 10:45 AM during family interview, R26's family reported that resident is taking Xarelto for an irregular heartbeat. On 07/18/18 at 12:09 PM Record Review (RR) for anticoagulant found that R26 did not have a care plan (CP) in place for use of Xarelto but there is a problem listed on her CP, "The resident has altered cardiovascular status r/t chronic A.Fib." There is no mention of an anticoagulant and side effects to monitor for. On 07/18/18 12:20 PM interviewed S23 and she confirmed that R26 is taking Xarelto, an anticoagulant, used to treat R26's Atrial Fibrillation and confirmed that this medication was not in R26's CP and it should have been. Noted that this information was captured in R26's quarterly Minimum Data Set (MDS), a clinical assessment of resident needs, dated 06/12/18. S23 stated that this medication (Xarelto) should have been in resident's CP along with the interventions to monitor for side effects.	4 174	the existing condition. -The MDS Coordinator updated the resident□s care plan on 7/18/2018. -The licensed staff collaborated with the hospice nurse to to implement appropriate interventions. -DON will also request a dental visit to check oral lesion. Resident #26 -On 7/18/18, the MDS Coordinator updated the resident□s care plan to reflect the use of Xarelto and side effects to monitor for. -The DON will conduct an inservice to train staff on utilizing the EHR to ensure that all direct care staff will be aware of the individualized approaches for each resident. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All residents receiving medications or other treatments to treat infections are potentially affected by the deficient practice. -All residents receiving anticoagulants are potentially affected by the deficient practice. -The charge nurse will initiate a care plan for any residents who are receiving anticoagulants or medications/treatments for infections. -All direct care staff will be trained on accessing each resident□s individualized care plans to review specific goals and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 174	Continued From page 12	4 174	interventions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -The facility matrix will be reviewed quarterly by the DON to ensure that any residents identified have care plans developed and implemented. -The annual inservice curriculum on dental care/oral hygiene will be reviewed every year to ensure that direct care staff are able to properly assess, identify, and report any abnormalities. The topics covered will be pertinent to common problems seen in long term care residents and how to address them. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The DON will conduct a quarterly quality assurance for the residents□ care plans. -Quarterly chart audits will include checking that direct care staff documentation reflects each resident□s individualized needs.	
4 176	1-94.1-43(d) Interdisciplinary care process (d) Implementation of the overall plan of care shall be documented in each resident's medical record.	4 176		8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 176	Continued From page 13 This Statute is not met as evidenced by: Based on record review (RR) and staff interview the facility failed to provide adequate monitoring for R13's antidepressant (Citalopram), antipsychotic (Quetiapine) and anticonvulsant (Depakote) which are ordered for the following diagnoses depression, dementia with agitation and dementia respectively. Findings include: On 07/18/18 at 12:05 PM during RR found that R13 had a care plan (CP) in place for physically aggressive behavior with an intervention to "administer medication as ordered. Monitor/document for side effects and effectiveness. Monitor behavior episodes and attempt to determine underlying cause. Document behavior and potential causes in behavior log." 07/18/18 05:05 PM interviewed R13's family member regarding R13 taking Seroquel and she stated that she wanted him to continue to take this medication to "keep him stable." R13's family member reported that last year R13 was at a day program and became agitated and was taken to Queen's ER to be treated and he was given Seroquel. R13's family member stated that his doctor discontinued the Trazodone. R13's family member wants to see how R13 does taking only Seroquel at the prescribed dose and maybe later lower the dose of Seroquel in the future. On 07/20/18 at 11:00 AM interviewed Registered Nurse (RN) 35 who stated that the charge nurse monitor's R13's behavior and side effects from Trazodone, Citalopram, Quetiapine and Depakote and documents this on the Behavior/Intervention Monthly Flow Record for July 2018. Noted that	4 176	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -The day shift charge nurse initiated a Behavior/Intervention Monthly Flow Record for each medication in question and indicated what specific behaviors and side effects are being monitored. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents receiving multiple psychotropic drugs are potentially affected by the deficient practice. -The DON will review and revise the facility□s Psychotropic Drug Policy & Procedure and Behavior/Intervention Monthly Flow Records for residents taking psychotropic medications. -The DON will conduct an inservice for all licensed staff regarding the revised Psychotropic Drug Policy & Procedure. -On a quarterly basis the Interdisciplinary Team (IDT) will review the results of the Behavior/Intervention Monthly Flow Records with residents/family members, provide education, and discuss a trial gradual dose reduction if appropriate. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 176	Continued From page 14 R13's sheet had 4 medications listed (as stated earlier) and 2 behaviors (yelling/verbal agitation and resistive to care) listed but nothing was listed for side effects. RN35 stated that they list the side effect if it is seen. Inquired how would anyone know which side effect was related to the four medications being monitored and RN35 was unable to answer.	4 176	recur -The DON will perform random, monthly checks to ensure that the Behavior/Intervention Monthly Flow Records reflect the behaviors and side effects being monitored, and ensure each medication has an adequate indication for use. -The DON will review the consultant pharmacist□s reports and discuss any recommendations with the resident/family members and the resident□s physician -The annual inservice curriculum for staff will include the monitoring of psychotropic medications, education provided to the resident/family, side effects, proper documentation, and communication with the IDT as needed. Licensed staff will also receive ongoing training on utilizing the EHR to accomplish these tasks. -The Psychotropic Drug Policy & Procedure will be reviewed on an annual basis and revised as necessary. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The DON will maintain a log of residents currently taking psychotropic medications to monitor use. -The DON and IDT will conduct quarterly audits on the use of psychotropic medications to assess facility-wide use, and identify any residents who may be appropriate for a gradual dose reduction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 182	Continued From page 15	4 182		
4 182	11-94.1-45(a) Dental services (a) Emergency and restorative dental services shall be available to each resident. This Statute is not met as evidenced by: Based on interview and record review the facility failed to assist the Resident (R)3 in obtaining routine dental care. The deficient practice placed R3 at risk for a decline in nutrition and a decrease in optimal health due to the loss of a crown. Findings include: During an interview with R3's family member F1 on 07/16/18 at 10:46 AM stated my wife lost a crown while she was eating and needs a new one, I guess I have to take care of this. I don't think the facility can help with this because it isn't an emergency. She is a heavy transfer and they use a lift to put her into bed. I talked to my dentist and he said that he is not sure how to get her into the dentist chair. We also need to transport her there, which presents a problem. Reviewed the most recent inter-disciplinary team (IDT) meeting notes. No documentation noted that there was a dental concern for R9. During an interview on 07/18/18 11:25 AM the Minimum Data Set (MDS) coordinator stated that she was aware of R3's lost crown and that the facility will usually tell the family if they need dental care and if they would like to have the teeth checked by an outside dentist,we can help them with that. F1 mentioned that R3 needed a new crown. An interview was conducted with the social	4 182	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -The charge nurse notified R3□s physician regarding the missing crown, received an order for a dental consult, and arranged transportation. The family was kept updated throughout this process. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken -All current and new residents that need a dental consult are potentially affected by the deficient practice. -The DON will initiate a dental service protocol in which the SWD will assist residents with arranging outside consults with available community resources if the facility on-call dentist is not able to provide the necessary services. -The protocol will also require the nursing staff to identify any dietary needs or referrals necessary to ensure the resident□s diet texture is appropriate in the interim. -The DON will conduct an inservice to train staff on how to utilize the dental	8/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 182	Continued From page 16 worker designee (SWD) on 07/18/18 at 10:40 AM whom stated that she is aware that R3 needs a new crown and that F1 will need to make the arrangements. She stated that R3 can eat okay without it.	4 182	service protocol. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -The annual inservice curriculum on dental care/oral hygiene will be reviewed every year to ensure that direct care staff are able to properly assess, identify, and report any abnormalities. The topics covered will be pertinent to common problems seen in long term care residents and how to address them. -The annual inservice curriculum will include training on assessing and providing a diet that the resident is able to safely consume. -The dental service protocol will be reviewed and revised by the DON on an annual basis. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The DON will review the facility dental service protocol annually and revise the protocol as necessary. -Quarterly chart audits will include checking for a baseline oral assessment, that staff are able to access this information, and that documentation reflects any new oral/dental issues.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 218	Continued From page 17	4 218		
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to provide a safe commode, in the bathroom between rooms 10 and 11, and failed to provide a clean shower room, in good repair, between rooms 7 and 8 . Findings include: 1) On 07/18/18 at 01:58 PM while walking from room 10 to 11 with CNA7 noted that the commode in the bathroom between rooms 10 and 11 had brownish orange areas underneath the seat and all along the legs. CNA7 stated that the brownish orange areas were "rust." Spoke with Director of Nursing (DON) who directed that S41 should be interviewed but was gone for the day but she will inform him to expect to be interviewed tomorrow. On 07/19/18 at 08:57 AM interviewed S41 and DON regarding commode in bathroom between rooms 10 and 11 and DON stated that "the commode is on order" and that they were aware of the condition of the commode. DON stated that she would provide a copy of this order with the date when the order was placed. On 07/20/18 at 12:20 PM interviewed DON again, requested the copy of documentation that she had ordered the commode chair prior to 07/18/18 when she was questioned about the commode and she stated that she called the vendor and they told her that they would give her	4 218	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -The commode in the bathroom between rooms 10 & 11 was replaced with a new commode on 7/19/18. -The shower room tiles between rooms 7 & 8 will be replaced by 8/30/2018 -The ceiling vent in the shower room between rooms 7 & 8 was cleaned on 7/20/18, and is free of dust. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents that are able to use a commode are potentially affected by the deficient practice. -All current and new residents in rooms 7 & 8 that access the shower room in question are potentially affected by the deficient practice. -All commodes in the facility were inspected and any rusted or otherwise unsafe commodes were replaced by the Housekeeping Supervisor. -The Housekeeping Supervisor will perform a weekly inspection of showers,	7/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 218	Continued From page 18 a note stating that she placed the order before 07/18/18 and she said it was ok that she would "take the tag." DON did not produce an invoice of order for the commode that was placed prior to 07/18/18 before end of survey. 2) On 07/19/18 at 11:15 AM the shower room in between room 7 and 8 revealed a thick coat of dust on the ceiling vent and the floor was dirty with several cracked and missing tiles. During an interview with S44 on 07/20/18 at approximately 9:45 AM in the shower room, the findings were discussed. S44 who agreed that the shower room vent and floors were in need of cleaning and repair.	4 218	bathrooms, and commodes to check they are safe for residents to use. Any repairs needed or items that need to be replaced will be reported promptly to either the Maintenance Supervisor or Assistant Administrator. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur -An extra commode was purchased to keep in storage so any rusted or unsafe commodes can be replaced promptly. -The facility will utilize a preventative maintenance log that will be updated weekly. The Housekeeping Supervisor will inspect shower rooms, bathrooms, and commodes, and update the log. The Housekeeping Supervisor will report any areas of concern to the Maintenance Supervisor or Assistant Administrator so they can be repaired or replaced. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The Assistant Administrator will review the preventive maintenance log weekly to check that equipment is being inspected. -The Assistant Administrator will perform quarterly audits to ensure that all equipment is working properly and safe for residents to use. -The facility assessment will be reviewed and updated annually to reflect the types	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 218	Continued From page 19	4 218	and quantities of physical equipment to ensure all residents□ needs are met.	
4 220	11-94.1-55(g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the facility shall be stored in a secured and locked area. This Statute is not met as evidenced by: Based on observation and interview the facility failed to lock the door to the storage closet where chemicals are used by the housekeeping and maintenance staff. The deficient practice placed the residents at an increased risk for accidents due to exposure by inhalation or ingestion of toxic chemicals. Findings include: During a visit to rooms 7 and 8 on 07/16/18 at 11:15 AM the supply closet door between the two resident rooms was found unlocked. Contents of the closet contained several small cans of abrasive cleaners with bleach and gallon containers with clear liquid and labeled with the word "hazardous, caution, etc. The outside of the door contained a large sign stating "Keep door locked at all times" and a hazardous materials (hazmat) biohazard sign. At 11:20 AM, the Director of Nursing (DON) was taken to the supply closet and made aware of the unlocked door. She locked the closet and stated that it should be kept locked since it contains toxic chemicals.	4 220	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -The Maintenance Supervisor replaced the locks on the doors to supply closets to a style that locks automatically when closed. The supply closet doors are also equipped with door closers. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All current and new residents are potentially affected by the deficient practice. -All residents who wander are potentially affected by the deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur	7/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 220	Continued From page 20	4 220	-The Housekeeping Supervisor will perform a random, weekly check that the supply closets are closed and locked. How the corrective action(s) will be monitored to ensure the deficient practice will not recur -The Housekeeping Supervisor will inspect the door closers and locks monthly to ensure they are working properly. Any needed repairs will be reported promptly to the Maintenance Supervisor or Assistant Administrator.	